Financial Policy

Thank you for choosing **Your Bronx Dentist** for your dental needs. It is our desire to provide the highest quality dental care to all of our patients. An important part of our mission is making the cost of quality care easy and manageable by offering several payment options .We ask that you read, agree to, and sign before any treatment is rendered.

Regarding Insurance

We will do our very best to maximize your insurance benefits. Please understand that the insurance contract is between the insurance company and you based off what your employer purchased. Recommended treatment by ***Your Bronx Dentist is never based on what your insurance company will pay.*** It is your responsibility to inform us of any new information regarding your insurance. If for some reason your insurance carrier has denied your claim, you will then be responsible for the full balance.

Payment Options

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. Payment can be made by Cash, Check, MasterCard, Visa, American Express or Discover. Your Bronx Dentist charges $40.00 (subject to change as bank fees increase) for returned checks.

With prior Approval special financing options with convenient monthly payments are available with the Care Credit healthcare credit card this allows for you to pay over time with No Annual Fee.

Missed Appointments

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.00. Please help us service you better by keeping scheduled appointments

Delinquent Balances

Unpaid balance over 30 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, any account with a balance over 90 days will be turned over for collection, you will be held responsible for any additional collection and/or associated fees.

Please Note:

Your Bronx Dentist requires payment at the beginning of treatment. If you choose to discontinue care before your treatment is complete, your refund will be determined upon review of your case. For plans requiring multiple appointments, alternative payment arrangements may be provided.

By signing this Financial Agreement, I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient, Parent or Guardian Signature: **Date:**

Patient Name (Please Print)